

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013940

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 172 Primary Registration District No. 4272 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) Waverly		c. CITY OR TOWN Grand Pass 0770	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kelling Clinic		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Reynolds Last		4. DATE OF DEATH Month April Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1959
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) F UNDER 1 YEAR Months Days 5 Hours 15
11. BIRTHPLACE (City and state or country) Grand Pass, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles L. Reynolds		13b. MOTHER'S MAIDEN NAME Joyce Ann Rich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Bula Rich		Address Grand Pass, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth			INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 15 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 776X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 4-26-59 4:00 a. to 4-27-59 and last saw him alive on 4-27-59		Death occurred on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Jordan Kelling M.D. (Doctor or Nurse)		22b. ADDRESS Waverly, Missouri	
22c. DATE SIGNED 4-28-59			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 4-27-1959	
23c. NAME OF CEMETERY Grand Pass Community		23d. LOCATION (City, town, or county) Saline County, Mo.	
24. FUNERAL DIRECTOR Gibson-Bailey Waverly, Mo.		25. DATE RECD. BY LOCAL REG. May 1st 59	
		26. REGISTRAR'S SIGNATURE Lute Jordan	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by James F. Gibson, Student Embalmer No. 572  
working under my personal supervision.

Student James F. Gibson  
Signature of Student Embalmer

Signed James F. Gibson

Licensed Embalmer No. 2961

P. O. Address Carroll

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.